

CERTIFICATE OF DEATH

Reg. Dist. No.

5001

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xcordova d. STREET ADDRESS Route 1, Box 294 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Howard Middle J Last Clayton			4. DATE OF DEATH Month April Day 4 Year 19 60		
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-14	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mill worker		10b. KIND OF BUSINESS OR INDUSTRY Truck Driver		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles Clayton		
14. MOTHER'S MAIDEN NAME Hattie Sherwood			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) xx (If yes, give war or dates of service) xx		
16. SOCIAL SECURITY NO. 915-26-5982			INFORMANT Bernice Clayton Address Easton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metro positoneal lymphosarcoma. 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt M.D.		ADDRESS (Street, city or town, state) 2195 Washington St. Easton, Md. DATE SIGNED APR 13 '60			
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 4/13/60		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.		22d. LOCATION (City, town, or county) (State) Easton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James D. Dashiell ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR APR 13 '60		24b. REGISTRAR'S SIGNATURE Orlando S. Kinn	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

200.9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18
5020 Item 9 Film G263 5/26/60 lwk
CERTIFICATE OF DEATH

06216

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman		c. LENGTH OF STAY IN lb 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		d. STREET ADDRESS 1 -----	
3. NAME OF DECEASED (Type or print) First Herbert Middle ----- Last Collins		4. DATE OF DEATH Month April Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) approx. 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY seafood plant	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hayes Collins		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 217-09-7551	
17. INFORMANT James W. Collins, Trappe, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 15 min. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 15 yrs. diabetes	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10, 1960 , to April 22, 1960 , that I last saw the deceased alive on April 21, 1960 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Wm M Reeser Sr		DATE SIGNED 4/23/60	
PHYSICIAN'S NAME (Type) Wm M REESER SR TILGHMAN MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/60	
22c. NAME OF CEMETERY OR CREMATORY Sherwood Church Cemt.		22d. LOCATION (City, town, or county) (State) Sherwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Thompson		24a. REC'D BY REGISTRAR St. Michaels, Md	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE MAY 23 '60	

CERTIFICATE OF DEATH

302

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15, 1900</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Occupation: <u>Engineer</u></p>		<p>8. Residence: <u>123 Main St.</u></p>	
<p>9. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Name of undertaker: <u>John Doe</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>		<p>12. Signature of informant: <u>[Signature]</u></p>	
<p>13. Name of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	

5021

CERTIFICATE OF DEATH

64981
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak		c. LENGTH OF STAY IN Tb 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tilghman		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VESTA Middle L. Last CUMMINGS		4. DATE OF DEATH Month April Day 10, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph L. Harrison		14. MOTHER'S MAIDEN NAME Sara E. Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Informant Address Mrs. Pauline Jenkins, Tilghman, Md.	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic coronary heart d. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-30 , 19 60 , to 4-10 , 19 60 , that I last saw the deceased alive on 4-10 , 19 60 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED GUY M. REESER, Jr., M.D. 4-11-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 12, 1960	
22c. NAME OF CEMETERY OR CREMATORY Tilghman Memorial		22d. LOCATION (City, town, or county) (State) Tilghman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. Hamilton Harrison		24a. REC'D BY REGISTRAR DATE APR 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

414.1

5002

CERTIFICATE OF DEATH

64982
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>4da. 8hr. 5min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Rural Denton 05x2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>Roll</u> <u>Depew</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>26</u> <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Lee Depew</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. Roll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 421-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Calcific aortic stenosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>< 15 minutes</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Apr. 27, 1960</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.		DATE SIGNED <u>Apr. 27, 1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 30, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rahway</u>	22d. LOCATION (City, town, or county) (State) <u>Rahway N. J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Vigor Kearns</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline S. Kearns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1943-44

1943-44

1943-44

1943-44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5022

CERTIFICATE OF DEATH

04984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton Rural				c. LENGTH OF STAY IN 1b 13 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS RFD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Theodore Middle E. Fletcher Last 				4. DATE OF DEATH Month April Day 14 Year 1960			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1895		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker				10b. KIND OF BUSINESS OR INDUSTRY Canned Goods		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Jeremiah B. Fletcher				14. MOTHER'S MAIDEN NAME Sarah Varnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-01-2046		17. INFORMANT Theo. E. Fletcher Address Preston, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis - left hemiplegia DUE TO Alcoholism, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (?) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1950 to 14 Apr 1960 , that I last saw the deceased alive on 13 Apr 1960 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thurston Harrison M.D.				ADDRESS (Street, city or town, state) Easton, Maryland DATE SIGNED 15 Apr 60			
PHYSICIAN'S NAME (Type) THURSTON HARRISON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 18,		22c. NAME OF CEMETERY OR CREMATORY Jr. O. U. A. M.		22d. LOCATION (City, town, or county) (State) Preston Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. M. Harrison ADDRESS Preston				24a. REC'D BY REGISTRAR DATE APR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
100 STATE STREET, ROOM 100
BOSTON, MASSACHUSETTS 02109

5003

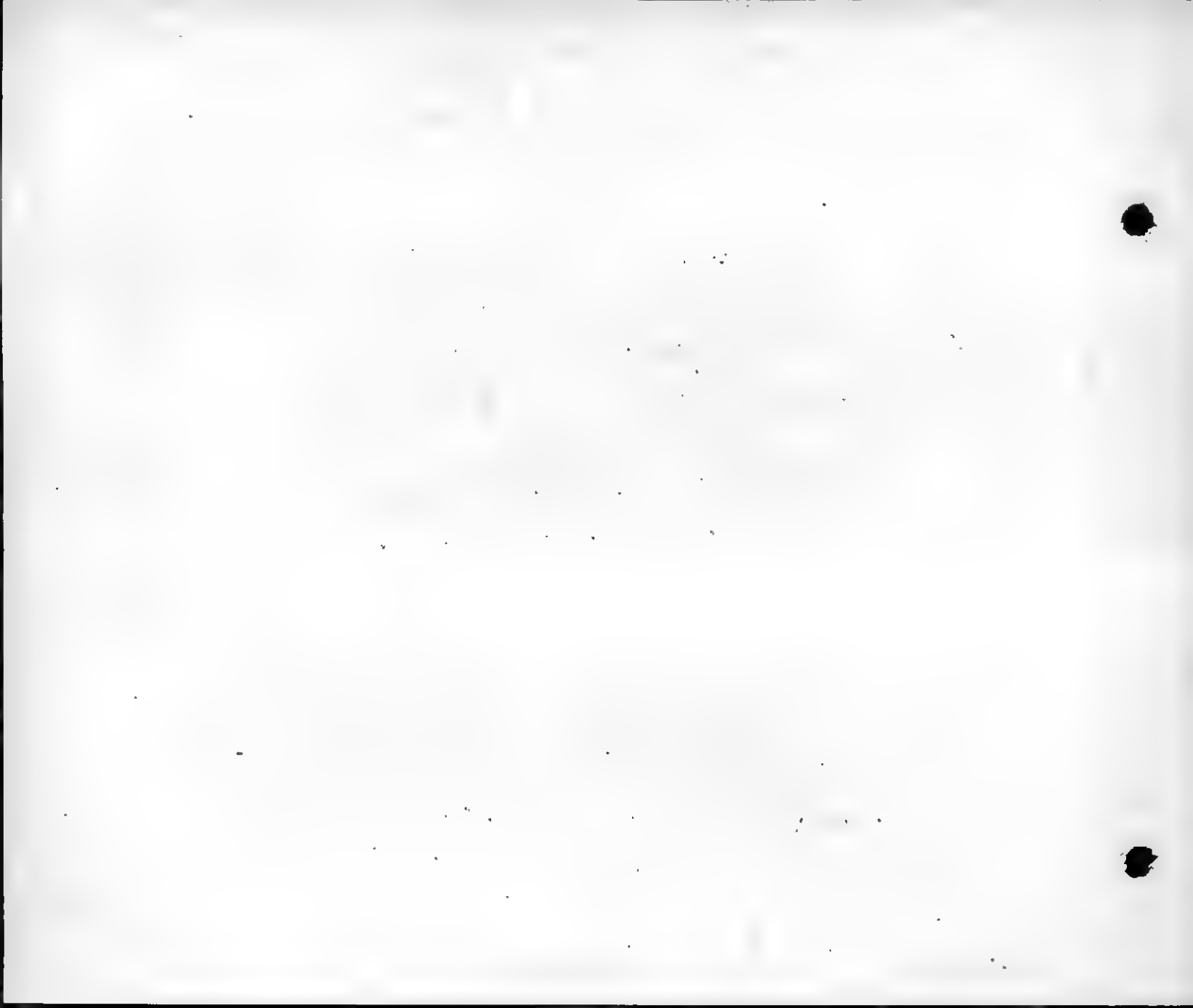
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE <i>md</i> b COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clarence McKinley Gibson</i>		4. DATE OF DEATH Month Day Year <i>April 17 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3 1882</i>
9. AGE (in years last birthday) yrs. <i>67</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nursery (Farm)</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Thomas Henry Gibson</i>		14. MOTHER'S MAIDEN NAME <i>Ida Gibson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Hypertensive Cardio Vasc. Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>142 X</i> (c) <i>12 days</i> <i>Years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-5-</i> 19 <i>60</i> to <i>4-17-</i> 19 <i>60</i> , that I last saw the deceased alive on <i>4-17-</i> 19 <i>60</i> , and that death occurred at <i>4:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald J. Bartley</i>		DATE SIGNED <i>4-17-60</i>	
PHYSICIAN'S NAME (Type) <i>DONALD BARTLEY</i>		ADDRESS (Street, city or town, state) <i>EASTON, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>4/21/60</i>	<i>Chapel Cemetery</i>	<i>Easton md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Darfield Easton md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 12 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5004

CERTIFICATE OF DEATH

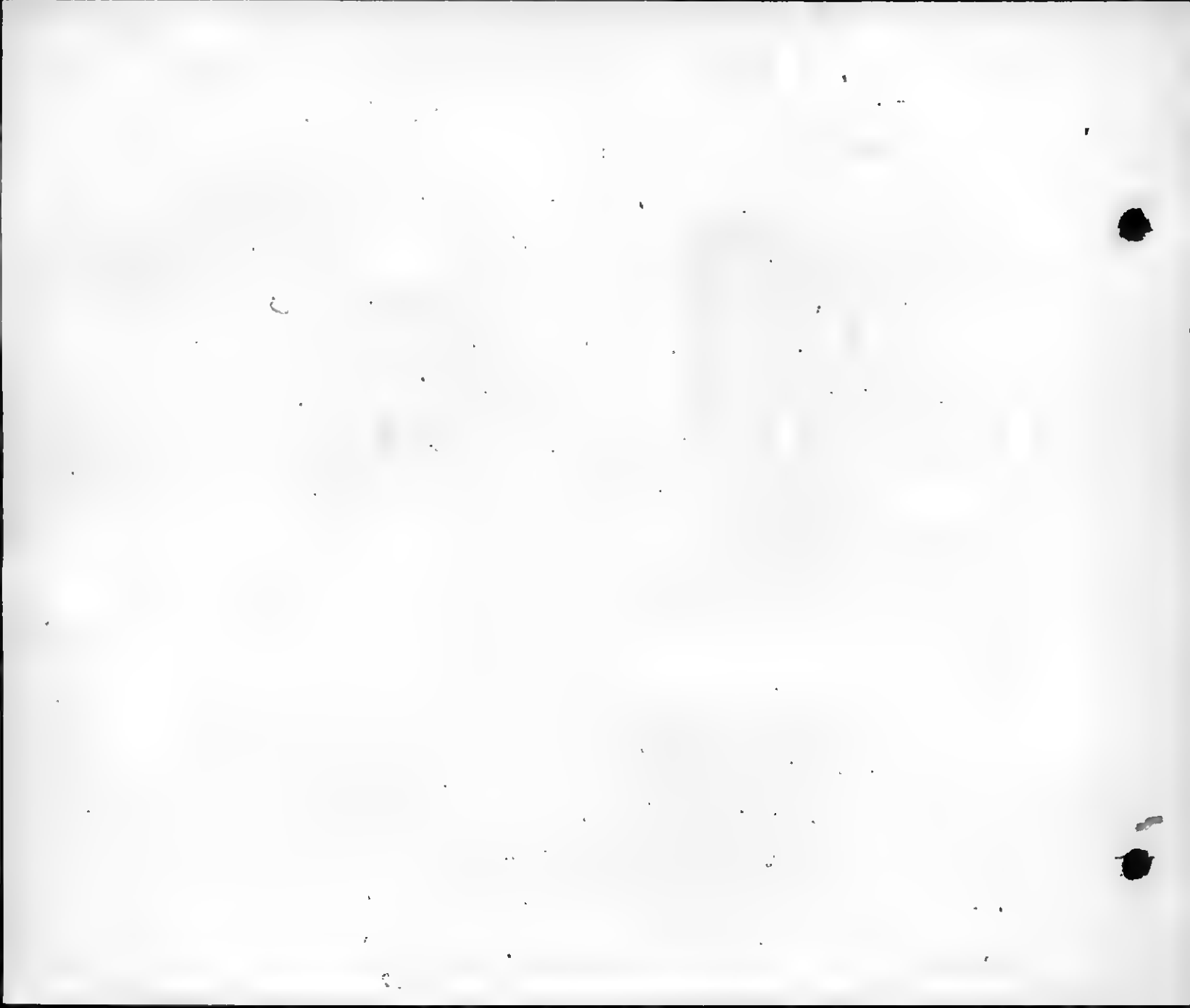
Reg. Dist. No.

14965

1. PLACE OF DEATH a. COUNTY TALBOT, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON MEMORIAL HOSH.		e. STREET ADDRESS Andrews Street	
3. NAME OF DECEASED (Type or print) Lillian A. GRAVES		4. DATE OF DEATH April 23, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/1867
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT EASTON HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 7, 1959 to April 23, 1960 , that I last saw the deceased alive on April 23, 1960 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jason F. G. Yee M.D.		ADDRESS (Street, city or town, state) Hurlock, Maryland	
PHYSICIAN'S NAME (Type) JASON F. G. YEE M.D.		DATE SIGNED 4/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/27/60	22c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEM.	22d. LOCATION (City, town, or county) (State) CAMBRIDGE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE St. Stephens, Cambridge, Md.		24a. REC'D BY REGISTRAR APR 26 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a fee is necessary, it should be paid to the Medical Examiner. Page 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 5005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64900

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VINE ST</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Wilson</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/24/18</u>	
9. AGE (In years) <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Goldsbrough</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XX</u>	
17. INFORMANT <u>Arthur Smith</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1</u> day	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Laura Mitty</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ELTY</u>		ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR <u>James B. Dashiell</u>		24a. REC'D BY REG STRAR DATE <u>APR 13 '60</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

A34

420.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5006

CERTIFICATE OF DEATH

Reg. Dist. No. 14987

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gardner</u> Middle <u>Hazen</u> Last <u>Hazen</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publisher</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>George H. Hazen</u>		14. MOTHER'S MAIDEN NAME <u>Ella Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Grace G. Hazen</u> Address <u>Chilbrook</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific aortic stenosis</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-1-1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, State) <u>219 S. West 117th St / 13 April 1960</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 14, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Noddam</u>		22d. LOCATION (City, town, or county) (State) <u>Noddam Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Easton</u>		24a. REC'D BY REGISTRAR <u>Easton Md</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>APR 18 1960</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

421.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5007

CERTIFICATE OF DEATH

Reg. Dist. No.

64968

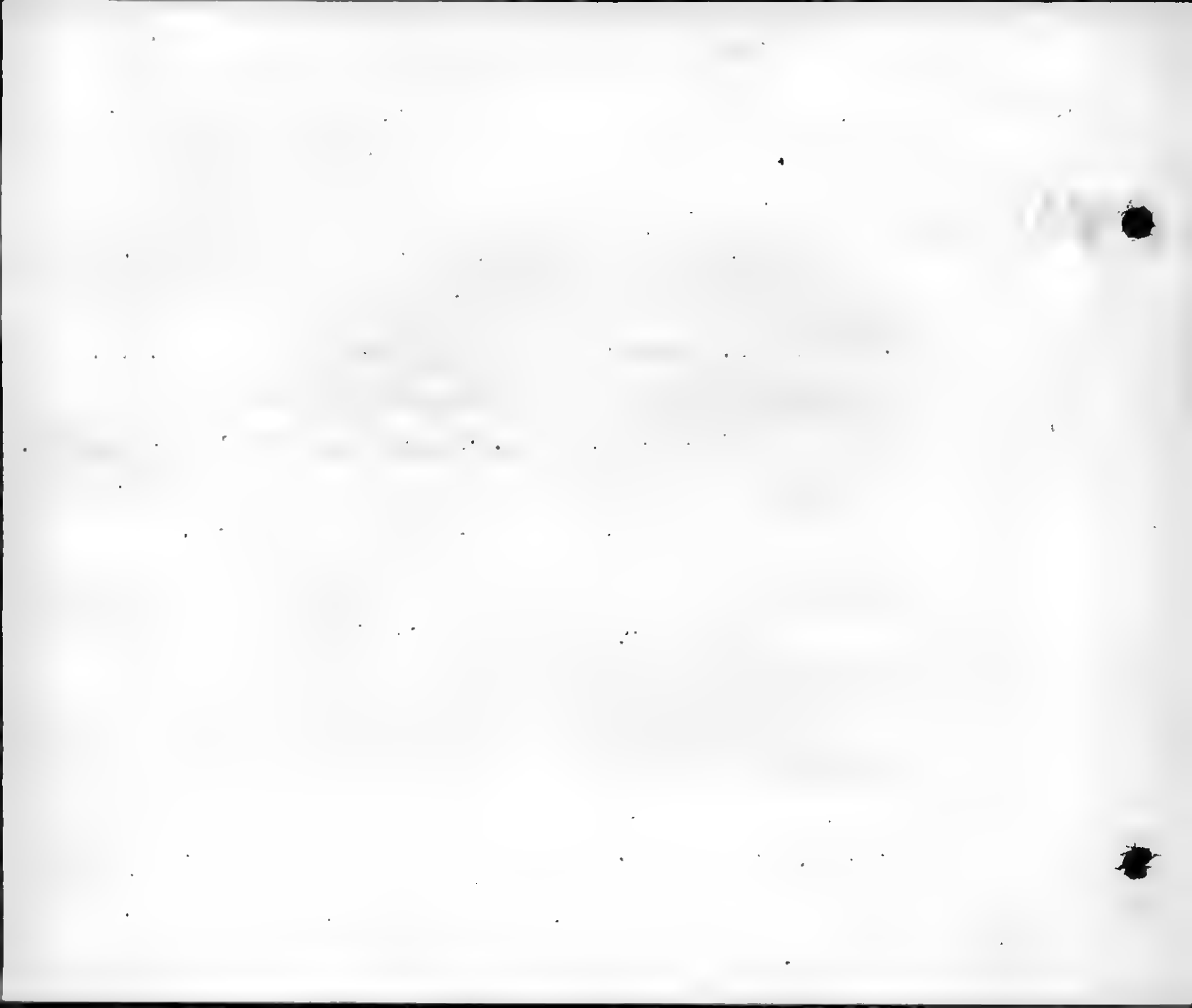
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN lb <u>5 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlock - Rural</u>			
f. STREET ADDRESS <u>Cabin Creek</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Emma</u> Last <u>Henry</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1873</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Widner Coulbourn</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Coulbourn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Earl Henry, Easton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> <u>4/10</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u> </u> DUE TO (c) <u> </u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>< 1 week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphoscoliotic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/6</u> , 19 <u>60</u> , to <u>4/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>60</u> , and that death occurred at <u>3:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>		DATE SIGNED <u>4-10-60</u>	
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Last New Market, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hampton & Son, Federalburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

491X

431

VS A1S (4)
1CM 9/CR



5018 CERTIFICATE OF DEATH

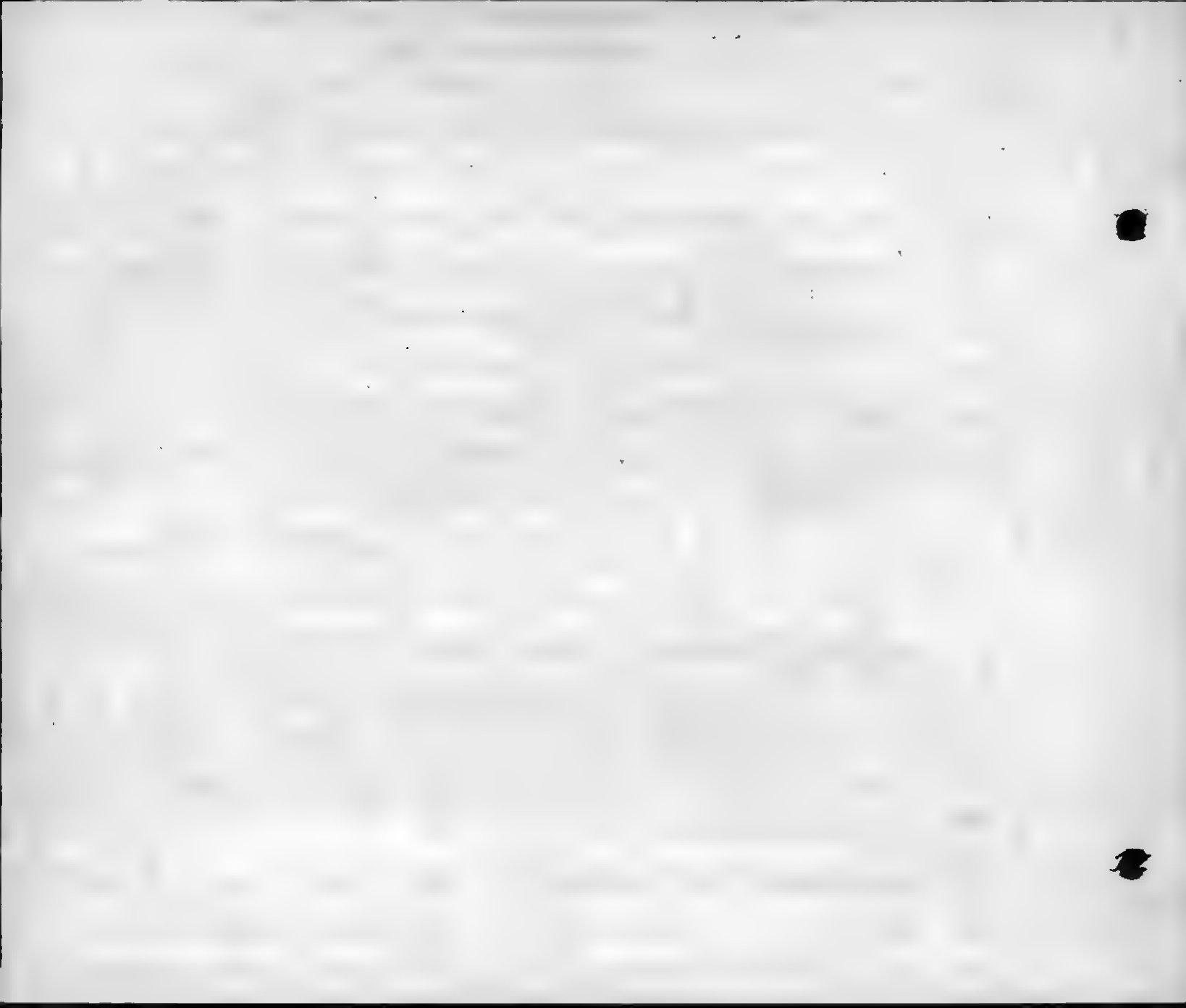
Reg. Dist. No.

14991

1. PLACE OF DEATH a. COUNTY <u>Salhat</u>			2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Freemanna</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels, Md.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rio Vista Nursing Home</u>			d. STREET ADDRESS <u>211 Broadway St.</u>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>ELIZABETH</u> Last <u>HOLDEN</u>			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1881</u>		9. AGE (In years last birthday) <u>78</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ch. mach. & md.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas H. Dodd</u>			14. MOTHER'S MAIDEN NAME <u>Annie M. Dodd</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Miss Ida M. Dodd</u> Address <u>Shipley St. Seaford Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebral arterial thrombosis</u> DUE TO (b) <u>atherosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2-4 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Time vessel disease</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>6-16</u> , 19 <u>57</u> to <u>4-3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-3</u> , 19 <u>60</u> , and that death occurred at <u>10:34</u> AM, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Harvey G. Larky</u>		ADDRESS (Street, city or town, state) <u>Seaford Del.</u>			
PHYSICIAN'S NAME (Type) <u>James M. R. R. R.</u>		DATE SIGNED <u>4-6-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 6</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey G. Larky</u>		ADDRESS <u>Seaford Del.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



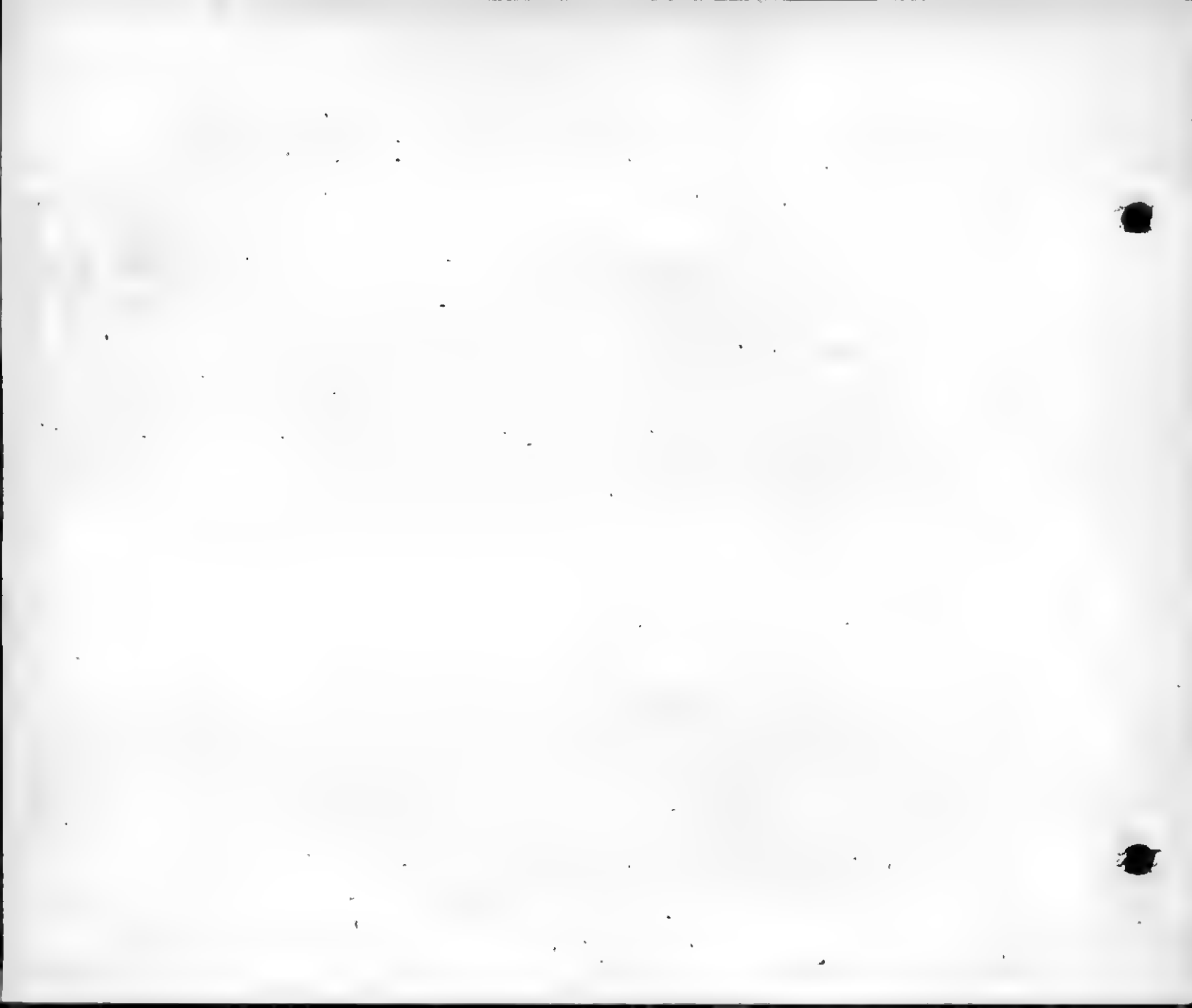
5010

CERTIFICATE OF DEATH

Reg. Dist. No.

43503

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE Catherine Jacobson</u>		4. DATE OF DEATH Month Day Year <u>April 18 1960</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 22-1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHRISTIAN ROSE</u>		14. MOTHER'S MAIDEN NAME <u>ANNA REDDING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>HILTON JACOBSON</u>		Address <u>CHESTER MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:05</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.		ADDRESS (Street, city or town, state) <u>EASTON MD</u> DATE SIGNED <u>4/18</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>		<u>EASTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SAINT PETERS</u>	22d. LOCATION (City, town, or county) (State) <u>QUEENSTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar J. Lane</u> ADDRESS <u>Chick Hill Rd.</u>		24a. REC'D BY REGISTRAR <u>APR 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Smith</u>



5011

CERTIFICATE OF DEATH

64994

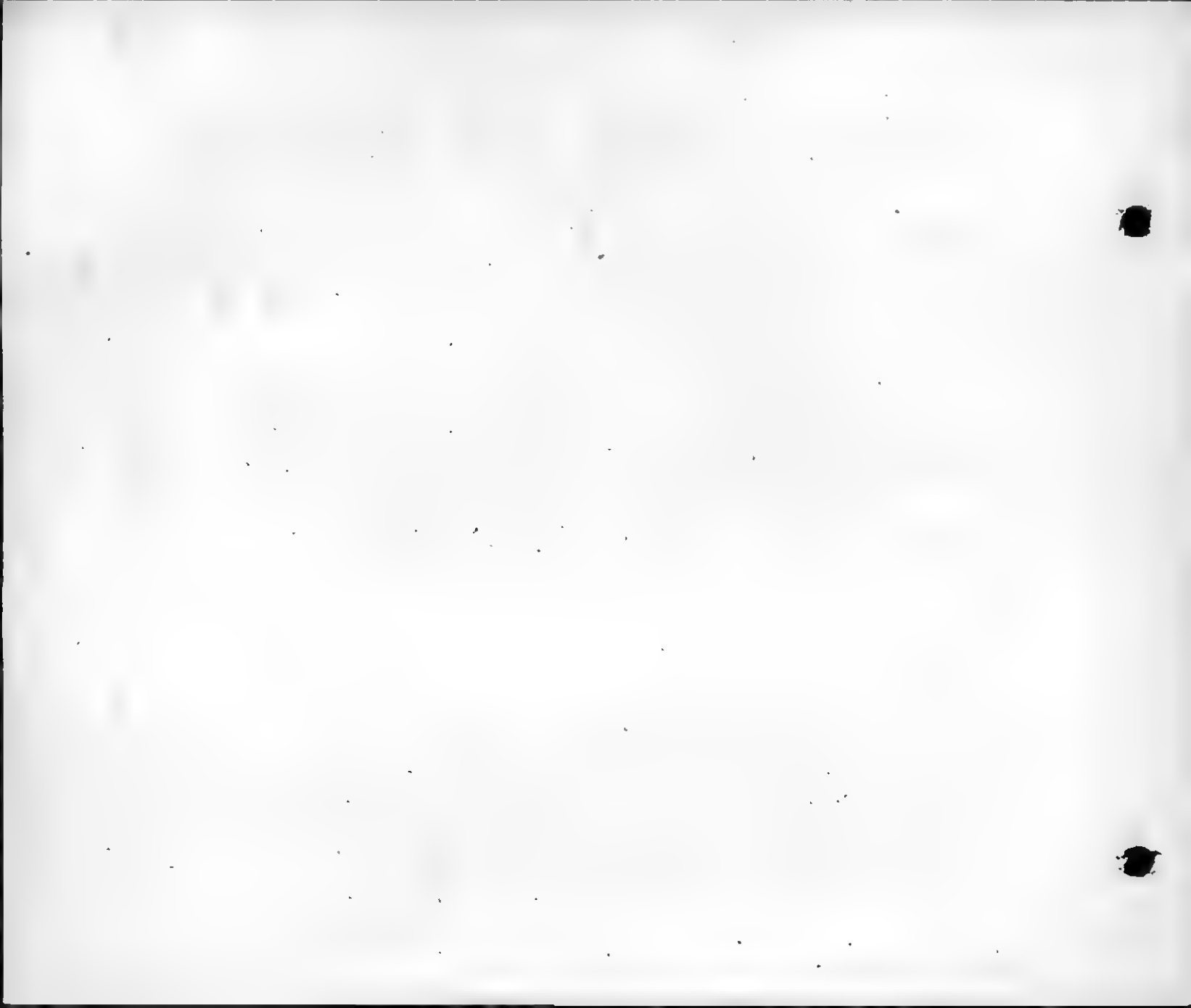
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Victor</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 28-1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Talbot Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO <u>217-28-3439</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> DUE TO (c) _____		18. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>2195 Washington St. H. 4</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>APR 12 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4-9-60</u>	22c. NAME OF CEMETERY, OR CREMATORY <u>Springhill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hamilton Harrison</u>		24. REC'D BY REGISTRAR <u>APR 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Thos S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



5012

CERTIFICATE OF DEATH

Reg. Dist. No.

4998

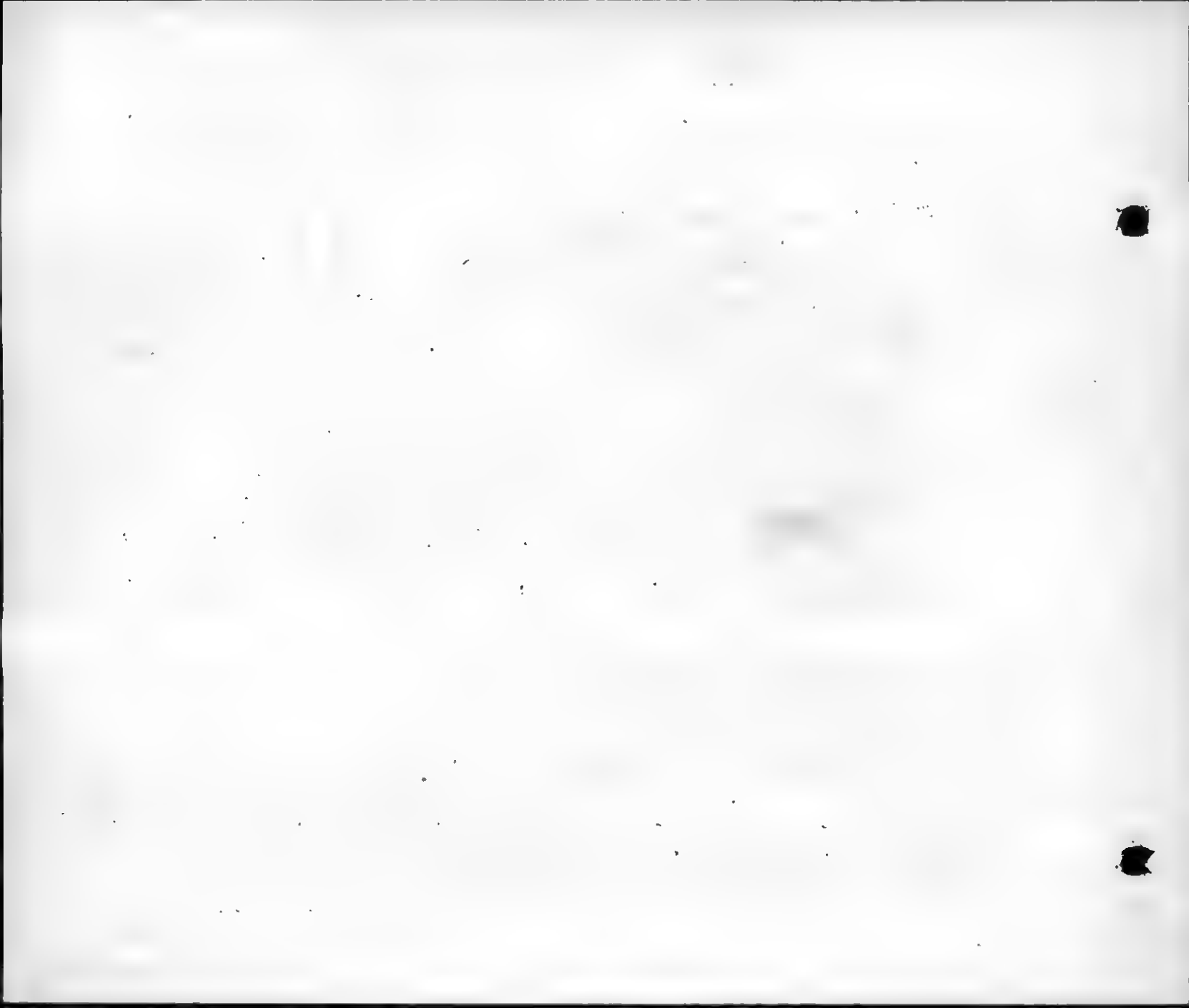
1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>12 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
3. NAME OF DECEASED (Type or print) First <u>Donah</u> Middle <u>Nichols</u> Last <u>Nichols</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 8, 1876</u>
9. AGE (In years lost birthday) yrs. <u>84</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Poole</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gambrill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Vincent Bassett, Hurlock, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u> <u>15 yrs.</u> <u>20 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5 April</u> , 19 <u>60</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. R. Trapnell</u> M.D.		ADDRESS (Street, city or town, state) <u>Federalburg, Maryland</u> DATE SIGNED <u>4-5-60</u>	
PHYSICIAN'S NAME (Type) <u>H. R. Trapnell, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hurlock, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son</u> ADDRESS <u>Federalburg</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Carroll A. Hall</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5013

CERTIFICATE OF DEATH

5000
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton	
c. LENGTH OF STAY IN lb 35 days		d. STREET ADDRESS 05x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha Blackstone Orme		4. DATE OF DEATH Month April Day 13 Year 1960	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1912
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 10 Days 21 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert H. Blackstone		14. MOTHER'S MAIDEN NAME Jennie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William A Orme		Address Denton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 hrs , 19 60 , to 5:15 a.m. , 19 60 , that I last saw the deceased alive on 13 Apr , 19 60 , and that death occurred at 10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thurston Harrison M.D.		ADDRESS (Street, city or town, state) Denton, Maryland DATE SIGNED 13 Apr 60	
PHYSICIAN'S NAME (Type) THURSTON HARRISON		EASTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF April 14, 1960	22c. NAME OF CEMETERY OR CREMATORY Denton	22d. LOCATION (City, town, or county) (State) Denton Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Harris ADDRESS Denton Md		24a. REC'D BY REGISTRAR APR 18 '60	24b. REGISTRAR'S SIGNATURE Charles L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1837

5014

CERTIFICATE OF DEATH

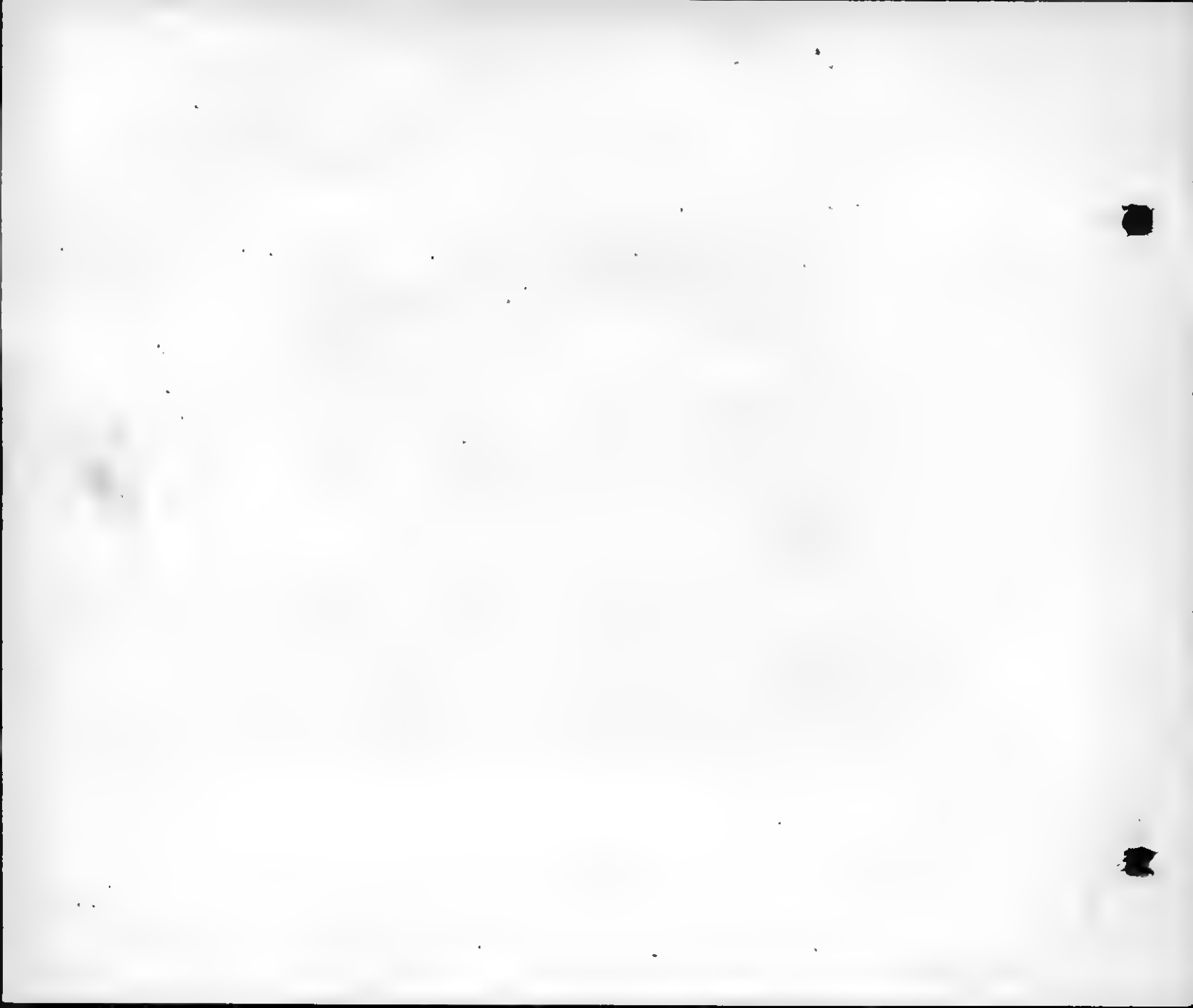
Reg. Dist. No.

65001

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>COROLANET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>BUCKERSVILLE C. 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Roe</u> Last <u>Poster</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16, 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Roe</u>		14. MOTHER'S MAIDEN NAME <u>M. Anna Callaway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Shirley Roe, Greenwood, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lymphosarcoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>1.1</u> DUE TO (c) <u>1.1</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>60</u> , to <u>4/6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>60</u> , and that death occurred at <u>5:25 P.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>none</u>		22b. DATE THEREOF <u>Apr 9/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore & Son</u> ADDRESS <u>Denton, Md</u>		24. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. Mary's</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MR. Julian</u> <u>Richardson</u>		4. DATE OF DEATH Month Day Year <u>4</u> - <u>11</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OF FACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/1894</u>
9. AGE (In years last birthday) yrs <u>65</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Apple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>INFORMANT</u> Address <u>Mr. Richard Richardson 16 T. Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO <u>Occlusion of coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2195 Washington St. Apple</u> DATE SIGNED <u>April 13, 1960</u>			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Helms</u> ADDRESS <u>East New Market</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

459x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5016 CERTIFICATE OF DEATH

Reg. Dist. No.

15668

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Amelia Julia Weber</i>		4. DATE OF DEATH Month Day Year <i>APRIL 26 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 9, 1872</i>
9. AGE (in years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>A. B. Meyhart</i>		14. MOTHER'S MAIDEN NAME <i>Julia Pierson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <i>INFORMANT</i>	
17. ADDRESS <i>Mrs. Chas. Richardson</i>		18. ADDRESS <i>Offord Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>			
DUE TO (b) <i>Hypertensive Arteriosclerosis</i>			
DUE TO (c) <i>Cardiovascular Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN 4, 1959</i> to <i>4/26, 1960</i> , that I last saw the deceased alive on <i>4/26, 1960</i> , and that death occurred at <i>2:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L. J. Eglseder</i>		ADDRESS (Street, city or town, state) <i>12 N. HANSON ST EASTON, MD.</i>	
PHYSICIAN'S NAME (Type) <i>L. J. EGLEDER</i>		DATE SIGNED <i>4/28/60</i>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>April 30, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wildwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Williamsport Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Neumann & Son</i>		ADDRESS <i>Easton, Md.</i>	
24. REC'D BY REGISTRAR <i>MAY 3 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5023

CERTIFICATE OF DEATH

Reg. Dist. No.

156-10

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>AUBREY W. WILLIS</u> First Middle Last		4. DATE OF DEATH <u>Apr 5, 1960</u> Month Day Year	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>June 19, 1881</u>
9 AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <u>U.S.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13 FATHER'S NAME <u>John F. Willis</u>	
14 MOTHER'S MAIDEN NAME <u>Lucie Ann Morray</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>1-97-0-1000</u>		INFORMANT <u>Miss Lina E. Singer</u> Address <u>Easton Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 week</u> (c) <u>yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 25, 1958</u> , to <u>Apr. 5, 1960</u> , that I last saw the deceased alive on <u>Apr. 5, 1960</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Shepard Krech, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>EASTON MARYLAND</u> DATE SIGNED <u>6/6/60</u>	
PHYSICIAN'S NAME (Type) <u>Shepard Krech, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wentworth Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Morris E. Newman, Sons</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneale</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5017

CERTIFICATE OF DEATH

5011
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN lb <u>8 hrs-40 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Alexander</u> Last <u>Winters</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-10-1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Canning Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Winters</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Mathews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if known) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>222-16-2220</u>			
INFORMANT <u>Gertrude Winters</u>				Address <u>Rural, Barclay, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12:45</u> , 19 <u>60</u> , to <u>1:30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1:30</u> , 19 <u>60</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.				DATE SIGNED <u>13th 60</u>			
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>				<u>EASTON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>		22d. LOCATION (City, town, or county) (State) <u>Marydel MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Boulaia Greenboro Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>			
ADDRESS <u>Greenboro Md.</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Kiser</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

49X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5019

CERTIFICATE OF DEATH

Reg. Dist. No.

5612

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home				/ d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENNIE Middle SPIES Last WRIGHT				4. DATE OF DEATH Month April Day 29 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Sunbury, Penns		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William M. Spies				14. MOTHER'S MAIDEN NAME Hannah Barbar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Earl W. Spies, 3539 Newland Rd, Balto, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO atherosclerotic coronary artery d. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-14 , 19 56 to 4-29 , 19 60 that I last saw the deceased alive on 4-29 , 19 60 , and that death occurred at 3:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) St Michaels Md DATE SIGNED 5-2-60 ACTUAL SIGNATURE Guy M. Reeser Jr M.D. PHYSICIAN'S NAME (Type) GUY M. REESER, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikeville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Hamilton Harrison				24a. REGISTRY DATE MAY 5 '60		24b. REGISTRY SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
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CONFIDENTIAL

SECRET

ATTENTION

Subject

Mr. [Name]

1945

Green [Name]

Place [Name]

1945

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